CHECK-UPS AFTER DELIVERY

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

➤ *This measure, optional in Medicaid HEDIS, is now required for Medicaid and commercial populations.*

Description

The percentage of Medicaid and commercially enrolled women who delivered (a) live birth(s) during the reporting year who were continuously enrolled 42 days after delivery, with no breaks in enrollment, who had a postpartum visit by the 42nd day after delivery.

Administrative Data Specification

Calculation: This specification uses hospital discharge and membership data to identify the number of women who delivered (a) live birth(s) during the reporting year. Claims/encounter data is used to identify those women who received postpartum care. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using all enrolled women who delivered (a) live birth(s) from January 1 through November 18 of the reporting year and who were continuously enrolled for 42 days after delivery, with no breaks in enrollment.

Note: *To ensure the completeness and validity of live-birth information, plans often use several data sources with different coding schemes. Codes are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone while others may be used as part of a combination of codes (e.g., V codes may be used alone; CPT-4 procedure codes may be used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed by the health plan to document live births, the plan is responsible for verifying that only live births are included in this measure.*

To identify deliveries resulting in live births, women who have been discharged with one of the following codes should be counted:

DRG codes: 370-375. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

Numerator: The number of women in the denominator for each of the two populations (Medicaid and commercial) who had a postpartum visit by the 42nd day after delivery. A woman is considered to have had a postpartum visit if a submitted claims/encounter includes any of the following codes and has a date of service between the hospital discharge date and the 42nd day after the delivery.

ICD-9-CM codes:

V24.1	Lactating mother (supervision of lactation)
V24.2	Routine postpartum follow-up

OR

CPT-codes:

59400	Vaginal delivery: Routine obstetric care including antepartum care, vaginal delivery and postpartum care
59410	Vaginal delivery, including postpartum care
59430	Postpartum care only (separate procedure)
59510	Cesarean delivery: Routine obstetric care including antepartum care, cesarean delivery and postpartum care
59515	Cesarean delivery, including postpartum care
59610	Routine obstetric care, including postpartum care
59614	Routine obstetric care, including postpartum care
59618	Routine obstetric care, including postpartum care
59622	Cesarean delivery, including postpartum care

Hybrid Method Specification

Calculation: This specification uses hospital discharge and membership data to identify the number of women who delivered (a) live birth(s) during the reporting year. Claims/encounter data and/or medical record review is used to identify those women who received postpartum care by the 42nd day after delivery. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using random samples of 411 Medicaid members and 411 commercial members from the health plan's eligible populations. Eligible members include Medicaid and commercially enrolled women who delivered (a) live birth(s) from January 1 through November 18 of the reporting year and who were continuously enrolled for 42 days after delivery, with no breaks in enrollment.

Note: *To ensure the completeness and validity of live-birth information, plans often use several data sources with different coding schemes. Codes are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone while others may be used as part of a combination of codes (e.g., V codes may be used alone; CPT-4 procedure codes may be used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed by the plan to document live births, the plan is responsible for verifying that only live births are included in this measure.*

To identify deliveries resulting in live births, women who have been discharged with one of the following codes should be counted:

DRG codes: 370-375. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

Numerator: The number of enrolled members in the denominator for each of the two populations (Medicaid and commercial) who had a postpartum visit by the 42nd day after delivery as documented through either administrative data medical record review.

Notes

- By specifying the denominator population to include only women with live births, this measure captures only a percentage of a plan members' pregnancies.
- Women who delivered in a birthing center should be included in this measure.
- When counting postpartum visits, include visits to physicians, nurse practitioners and midwives.

TREATING CHILDREN'S EAR INFECTIONS

New Measure

Description

The percentage of Medicaid and commercially enrolled children who were diagnosed with an uncomplicated episode of acute otitis media during the reporting year, who were continuously enrolled for six months immediately preceding the diagnosis or, if the child was younger than six months old at the time of diagnosis, continuously enrolled since birth, and who were dispensed an antibiotic other than a preferred antibiotic. The rate reported is 1 – (numerator/denominator).

Health plans should only count the first uncomplicated episode of acute otitis media occurring during the reporting year, and no child should be counted more than once in this measure. Plans should count in this measure only those members who have had no breaks in enrollment during the six months preceding the first episode or, if the child was younger than six months old at the time of diagnosis, since birth.

Note: *The inverted rate is reported in this measure to be consistent with other Effectiveness of Care measures: a higher rate indicates better performance.*

Administrative Data Specification

Calculation: This specification uses membership data and claims/encounter to identify children at least six weeks old but less than 60 months (five years) old who were diagnosed with an uncomplicated episode of acute otitis media during the reporting year. Pharmacy data is used to identify children who were dispensed an antibiotic other than a preferred antimicrobial agent. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived from the number of enrolled children who meet the following criteria:

- Who were diagnosed during the reporting year with an uncomplicated episode of acute otitis media. Plans should use the following ICD-9-CM principal diagnosis codes to identify an uncomplicated episode of acute otitis media: 382.4, 382.9, 382.00 or 382.01.

  AND

- Who were at least six weeks old but less than 60 months (five years) old at the time of diagnosis.

  AND

- Who were continuously enrolled for six months immediately preceding the diagnosis or, if the child was younger than six months old at the time of diagnosis, since birth.

  AND

Who were not identified as having a diagnosis of an infectious comorbidity or underlying disorder of immunity (refer to Table 1G) occurring on the same date of service or within six months prior to the diagnosis of acute otitis media.

AND

Who were not identified as having a previous diagnosis of acute otitis media within the preceding six months (i.e., ICD-9-CM diagnosis codes 382.4, 382.9, 382.00 or 382.01).

Note: Health plans should use only the first uncomplicated episode in the reporting year to calculate this measure.

Numerator: The number of children in the denominator for each of the two populations (Medicaid and commercial) who were dispensed an antibiotic other than a preferred antimicrobial (either amoxicillin or trimethoprim-sulfamethoxazole). The prescription for any antibiotic other than amoxicillin or trimethoprim-sulfamethoxazole should have been dispensed within two days of the diagnosis to ensure that it was prescribed for the acute otitis media episode. The following prescriptions correspond to trimethoprim-sulfamethoxazole and do not count in the numerator: Bactrim, Septra and Sulfatrim Suspension.

Rate: 1 – (Numerator/Denominator).

Hybrid Method Specification

Calculation: This specification uses membership and claims/encounter to identify children at least six weeks old but less than 60 months (five years) old who were diagnosed with an uncomplicated episode of acute otitis media during the reporting year. Pharmacy data and/or medical record review is used to identify children who were dispensed an antibiotic other than a preferred antimicrobial agent. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using random samples of 411 Medicaid enrolled children and 411 commercially enrolled children who meet the following criteria:

Who were diagnosed during the reporting year with an uncomplicated episode of acute otitis media. Plans should use the following ICD-9-CM principal diagnosis codes to identify an uncomplicated episode of acute otitis media: 382.4, 382.9, 382.00 or 382.01.

AND

Who were at least six weeks old but less than 60 months (five years) old at the time of diagnosis.

AND

Who were continuously enrolled for six months immediately preceding the diagnosis or, if the child was younger than six months old at the time of diagnosis, since birth.

AND

EFFECTIVENESS

Who were not identified as having a diagnosis of an infectious comorbidity or underlying disorder of immunity (refer to Table 1G) occurring on the same date of service or within six months prior to the diagnosis of acute otitis media.

AND

Who were not identified as having a previous diagnosis of acute otitis media within the preceding six months (i.e., ICD-9-CM diagnosis codes 382.4, 382.9, 382.00 or 382.01).

Note: Health plans should use only the first uncomplicated episode in the reporting year to calculate this measure.

Numerator: The number of children in the denominator for each of the two populations (Medicaid and commercial) who were dispensed an antibiotic other than a preferred antimicrobial (either amoxicillin or trimethoprim-sulfamethoxazole) as documented through either the pharmacy data or medical record review. The prescription for any antibiotic other than amoxicillin or trimethoprim-sulfamethoxazole should have been dispensed within two days of the diagnosis to ensure that it was prescribed for the acute otitis media episode. The following prescriptions correspond to trimethoprim-sulfamethoxazole and do not count in the numerator: Bactrim, Septra and Sulfatrim Suspension.

Rate: 1 – (Numerator/Denominator).

Notes

- Plans should only include children in the denominator for whom the plan manages or provides a pharmacy benefit in order to accurately identify children who were not dispensed a preferred antibiotic and document the percentage of children who were at least six weeks old but less than 60 months old during the reporting year for whom the plans manages or provides a pharmacy benefit.
- A child who is not treated with any antibiotic should be counted in the denominator but should not be counted in the numerator.
- Plans may identify those children for whom a previous diagnosis of otitis media occurred within the continuous enrollment period and exclude them from the measure.
- Plans should only count the first episode of acute otitis media occurring during the reporting year. No child should be counted more than once in this measure.
- Plans may exclude from the denominator children who are identified as either having an allergy to amoxicillin and trimethoprim-sulfamethoxazole or having an infectious comorbidity or underlying immunity disorder on the same date of service or within six months prior to the diagnosis of acute otitis media as documented through either administrative data or medical record review. Refer to Table 1G for the list of comorbidities or underlying immunity disorders and related codes.
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.

Table 1G: Infectious Comorbidities or Underlying Disorders of Immunity

Infection	ICD-9-CM Code
Intestinal infection	001.x-002.x, 003.0-003.1, 003.2x, 003.8-003.9, 004.x-007.x, 008.xx, 009.x
Tuberculosis	011.xx-018.xx
Zoonotic bacterial disease	020.x-023.x, 024, 025, 026.x-027.x
Leprosy & other mycobacterial diseases	030.x-031.x
Diphtheria	032.xx
Whooping cough	033.x
Erysipelas	035
Meningococcal infection	036.xx
Septicemia	038.xx
Actinomycotic disease	039.x
Other bacterial infection	040.xx, 041.xx
HIV infection	042
Chlamydial disease	076.x, 077.xx-079.xx
Rickettsioses & arthropod disease	080, 081.x1-083.x, 087.x-088.x
Syphilis & other venereal diseases	090.xx-091.xx, 092.x, 093.xx-094.xx, 095.x, 096, 097.x, 098.0, 098.1x, 098.2, 098.3x, 098.4x, 098.5x, 098.6, 098.7, 098.8x, 099.0, 099.1, 099.2, 099.3, 099.4x, 099.5x, 099.8, 099.9
Other spirochetal disease	100.x, 101, 102.x-104.x
Other infectious & parasitic diseases	130.x, 131.0x, 131.8, 131.9, 136.x
Malignant neoplasm	140.x-165.x, 170, 170.x, 171.x, 172.x, 173.x, 174.x, 175.x, 176.x, 179, 180.x, 181, 182.x, 183.x, 184.x, 185, 186.x, 187.x, 188.x, 189.x, 190.x, 191.x, 192.x, 193, 194.x, 195.x, 196.x, 197.x, 198.x, 199.x, 200.xx-202.xx, 203.x0-208.x0, 203.x1-208.x1, 230.x -235.x, 236.xx, 237.xx, 238.x-240.x
Immune disease	279.0x-279.1x, 279.2-279.4, 279.8, 279.9
Sickle cell disease and other hemoglobinopathy	282.6x, 282.7
Disease of white blood cells	288.x
Other disease of spleen	289.5x
Bacterial meningitis	320.0, 320.1, 320.2, 320.3, 320.7, 320.8x, 320.9
Meningitis	321.x-323.x
Intracranial and intraspinal abscess	324.0, 324.1, 324.9
Purulent endophthalmitis	360.0x-360.1x
Infection of conjunctiva	372.0x-372.3x
Inflammation of eyelids	373.xx
Disorders of the orbit	376.0x-376.1x
Disorders of external ear	380.0x-380.2x
Chronic otitis media	381.1x-381.2x, 381.3, 381.5x-381.6x, 381.7, 381.8x, 381.9, 382.1-382.3
Mastoiditis	383.xx
Disorders of tympanic membrane NEC	384.0x, 384.1, 384.2x, 384.8x, 384.9

Table 1G: Infectious Comorbidities or Underlying Disorders of Immunity

Infection	ICD-9-CM Code
Disorders middle ear and mastoid NEC	385.0x-385.3x, 385.8x, 385.9
Otorrhea	388.6x
Acute rheumatic fever	390, 391.x, 392.0, 392.9, 393, 398.0, 398.9x
Pericarditis/Endocarditis/Myocarditis	420, 420.0, 420.9x, 421.x, 422.0, 422.9x, 429.0
Acute Laryngitis/Tracheitis	464.0, 464.1x-464.3x, 464.4
Acute bronchiolitis	466.1
Chronic pharyngitis and nasopharyngitis	472.1, 472.2
Chronic sinusitis	473.0, 473.1, 473.2, 473.3, 473.8, 473.9
Chronic T&A disease	474.0, 474.1x, 474.2, 474.8, 474.9
Peritonsillar abscess	475
Chronic laryngitis and laryngotracheitis	476.0, 476.1
Other respiratory disease	478.0, 478.1, 478.2x, 478.3x, 478.4-478.6, 478.7x, 478.8, 478.9
Pneumococcal pneumonia	481
Other bacterial pneumonia	482.0, 482.1, 482.2, 482.3x, 482.4, 482.8x, 482.9
Pneumonia other specified organism	483.0, 483.8
Pneumonia in other infectious disease	484.x
Bronchopneumonia	485
Pneumonia unspecified	486
Chronic bronchitis	491.0, 491.1, 491.2x, 491.8, 491.9
Bronchiectasis	494
Chronic airway obstruction, NEC	496
Pleurisy	511.0, 511.1, 511.8, 511.9
Lung abscess	513.0, 513.1
Other respiratory system diseases	519.x
Oral soft tissue infection	528.3
Appendicitis	540.0, 540.1, 540.9, 541, 542
Cholecystitis	574.6x-574.8x, 575.0, 575.1x
Cholangitis	576.1
Pancreatitis	577.0, 577.1, 577.9
Acute glomerulonephritis	580.0, 580.4, 580.8x, 580.9
Kidney infection	590.0x-590.1x, 590.2, 590.3, 590.8x, 590.9
Cystitis	595.0-595.4, 595.8x, 595.9

Table 1G: Infectious Comorbidities or Underlying Disorders of Immunity

Infection	ICD-9-CM Code
Urethritis	597.0, 597.8x
Urinary tract infection	599.0
Orchitis and epididymitis	604.0, 604.9x
Infection of the male genitals	607.1, 607.2, 608.4
Female pelvic inflammatory disease	614.x, 615.0, 615.1, 615.9
Other female genital inflammatory disease	616.0, 616.1x, 616.2-616.4, 616.5x, 616.8, 616.9
Infection of skin and soft tissue	680.x, 681.xx, 682.x, 683, 684, 685.0, 685.1, 686.0, 686.1, 686.8, 686.9
Infectious arthropathy	711.0x, 711.4x, 711.9x
Infectious myositis	728.0
Fasciitis, unspecified	729.4
Osteomyelitis	730.xx

BETA BLOCKER TREATMENT AFTER A HEART ATTACK

New Measure

Description

The percentage of Medicaid, commercial and Medicare risk members age 35 years and older during the reporting year, who were hospitalized and discharged alive during the reporting year with a diagnosis of acute myocardial infarction (AMI) and who received a prescription for beta blockers upon discharge.

Administrative Data Specification

Calculation: This specification uses membership data and claims/encounter data to identify adults age 35 years and older during the reporting year who were hospitalized and discharged alive during the reporting year with a diagnosis of AMI. Hospital discharge abstract data and pharmacy data are used to identify a prescription for beta blockers at the time of discharge. Separate calculations are required for the Medicaid, commercial and Medicare risk populations.

Denominator: Three separate denominators, one for each of the three required calculations, are derived using all members age 35 years and older as of December 31 of the reporting year who were hospitalized and discharged alive during the reporting year with a principal diagnosis of AMI (ICD-9-CM code 410.xx) and who were not identified as having a contraindication to beta blockers. Refer to Table 1H for a list of conditions and related ICD-9-CM codes for exclusions from the measure.

Numerator: The number of adults in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) who received a prescription for beta blockers within seven days after discharge from the hospital with a diagnosis of AMI or within 30 days prior to the hospitalization for AMI. The following prescriptions correspond to beta blockers and count toward this measure:

Acebutolol HCl, Atenolol, Betaxolol HCl, Bisoprolol Fumarate, Carteolol HCl, Esmolol HCl, Labetalol HCl, Metoprolol Succinate, Metoprolol Tartrate, Nadolol, Penbutolol Sulfate, Pindolol, Propranolol HCl, Sotalol Hcl and Timolol Maleate.

Hybrid Method Specification

Calculation: This specification uses membership data and claims/encounter data to identify adults age 35 years and older during the reporting year who were hospitalized and discharged alive during the reporting year with a diagnosis of AMI. Hospital discharge abstract data, pharmacy data and/or medical record review are used to identify a prescription for beta blockers at the time of discharge. Separate calculations are required for the Medicaid, commercial and Medicare risk populations.

Denominator: Three separate denominators, one for each of the three required calculations, are derived using random samples of 411 Medicaid members, 411 commercial members and 411 Medicare risk members drawn from the health plan's eligible populations. Eligible members include, respectively, Medicaid adults, commercial adults and Medicare risk adults age 35 years and older as of December 31 of

the reporting year who were hospitalized and discharged alive during the reporting year with a principal diagnosis of AMI (ICD-9-CM code 410.xx), and who were not identified as having a contraindication to beta blockers. Refer to Table 1H for a listing of conditions and related ICD-9-CM diagnosis codes for exclusions from the measure.

Numerator: The number of adults in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) who received a prescription for beta blockers within seven days after discharge from the hospital with a diagnosis of AMI or within 30 days prior to the hospitalization for AMI as documented through either administrative data or medical record review. The following prescriptions correspond to beta blockers and count toward this measure:

Acebutolol HCl, Atenolol, Betaxolol HCl, Bisoprolol Fumarate, Carteolol HCl, Esmolol HCl, Labetalol HCl, Metoprolol Succinate, Metoprolol Tartrate, Nadolol, Penbutolol Sulfate, Pindolol, Propranolol HCl, Sotalol HCl and Timolol Maleate.

Notes

- Plans are strongly encouraged to exclude from the denominator members who are identified through either administrative data or medical record review as having a contraindication to beta blocker therapy, because the number of individuals with contraindications is likely to be relatively large. Refer to Table 1H for the listing of contraindications to beta blocker therapy.
- Plans are strongly encouraged to exclude from the denominator members who are identified through either administrative data or medical record review as having had a previous failure with beta blocker therapy.
- In cases where patients have had more than one episode of AMI (as indicated by ICD-9-CM diagnosis code 410.xx) during the reporting year, only the first episode should be included in this measure. Any episode with ICD-9-CM diagnosis code 410.x2 (AMI, subsequent episode of care) should be excluded from this measure.
- Plans should document the percentage of members in the denominator for whom the plan manages or provides the pharmacy benefit. The denominator of this measure includes all members who have been diagnosed during the reporting year with an AMI regardless of whether the plan manages or provides the pharmacy benefit because the number of members eligible for this measure is likely to be small.

Table 1H: Contraindications to Beta Blockers

Description of Contraindication	ICD-9-CM Code
Insulin dependent diabetes mellitus	250.x1, 250.x3
History of asthma	493.xx
Heart block > 1 degree	426.0, 426.12, 426.13, 426.2, 426.3, 426.4, 426.54, 426.7
Sinus bradycardia	427.81
CHF	398.91, 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 404.03, 404.13, 404.93, 428.0
Left ventricular dysfunction	428.1
COPD	491.20, 491.21, 492.0, 492.8, 496, 518.2, 506.4

EYE EXAMS FOR PEOPLE WITH DIABETES

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *The upper age limit has been removed.*
- ➤ *Specifications for the denominator have been modified: Method A in Medicaid HEDIS and Method 1 in HEDIS 2.5 have been deleted.*
- ➤ *This measure, optional in Medicaid HEDIS, is now required for Medicaid members.*
- ➤ *This measure now applies to the Medicare risk population.*

Description

The percentage of Medicaid, commercial and Medicare risk members with diabetes (Type I and Type II) age 31 years and older, who were continuously enrolled during the reporting year, and who had a retinal examination during the reporting year. Enrollees who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Administrative Data Specification

Calculation: This specification uses ambulatory claims/encounter data or pharmacy data to identify members with diabetes and ambulatory claims/encounter data to identify members who received a retinal exam during the reporting year. Separate calculations are required for the Medicaid, commercial, and Medicare risk populations.

Note: *Method A from Medicaid HEDIS and Method 1 from HEDIS 2.5 were deleted in favor of what was referred to as Method B or Method 2, because Method B/2 is preferred to capture diabetics treated through diet and exercise.*

Denominator: Three separate denominators, one for each of the three required calculations, are derived using all members age 31 years or older as of December 31 of the reporting year, who were members of the health plan as of December 31 of the reporting year, who were continuously enrolled during the reporting year (including enrollees who have had no more than one break in enrollment of up to 45 days during the reporting year) and identified as diabetic:

Those who were dispensed insulin and/or oral hypoglycemics during the reporting year on an ambulatory basis.

OR

Those who had two face-to-face encounters in an ambulatory setting or one face-to-face encounter in an inpatient or emergency room setting with a diagnosis of diabetes (ICD-9-CM code 250.xx, 357.2, 362.0x or 366.41). Use the following codes to identify ambulatory, inpatient and ER encounters:

UB-92 revenue codes (Form Locator 42):

10X, 11X, 12X, 13X, 14X, 15X, 16X, 17X, 20X, 21X, 22X, 45X, 49X, 50X, 51X, 52X, 53X, 55X, 57X, 58X, 59X, 65X, 66X, 72X, 76X, 80X, 82X, 83X, 88X, 92X, 94X, 96X, 97X and 98X.

CPT-4 codes:

Office or other outpatient services

99201-99205

99211-99215

99217-99220

99241-99245

99271-99275

99281-99288

Inpatient Services

99221-99223

99231-99233

99238-99239

99251-99255

99261-99263

99291-99292

Prolonged physician service

99354-99357

Preventive medicine

99381-99387

99391-99397

99401-99404

99411-99412

99420-99429

Home services

99341-99343

99351-99353

Comprehensive nursing facility assessments

99301-99303

Subsequent nursing facility care

99311-99313

Domiciliary, rest home or custodial care services

99321-99323

99331-99333

Other evaluation and management services

99499

Ophthalmology and optometry

92002-92014

Note: *Many plans find a high rate of false positives when they use laboratory data to identify diabetics, because diabetes diagnosis codes frequently are reported on laboratory tests used to rule out diabetes. Therefore, laboratory data should not be used to identify diabetics.*

Numerator: The number of members in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) who have a retinal ophthalmoscopic examination performed by an eye-care professional during the reporting year.

A person is counted as having a retinal ophthalmoscopic examination if he or she has had a claim/encounter with a service date during the reporting year in which one or more of the following services were provided:

CPT-4 codes:

92002	Ophthalmic services, intermediate, new patient
92004	Ophthalmic services, comprehensive, new patient
92012	Ophthalmic services, intermediate, established patient
92014	Ophthalmic services, comprehensive, established patient
92018	Ophthalmic exam, general anesthesia, complete
92019	Ophthalmic exam, general anesthesia, limited
92225	Ophthalmoscopy, extended-initial
92226	Ophthalmoscopy, extended-subsequent
92235	Fluorescein angiography (includes multiframe imaging) with medical diagnostic evaluation
92250	Fundus photography with medical diagnostic evaluation

Hybrid Method Specification

Calculation: This specification uses ambulatory claims/encounter data or pharmacy data to identify members with diabetes. Ambulatory claims/encounter data and/or medical record review are used to identify individuals who received a retinal exam during the reporting year. Separate calculations are required for the Medicaid, commercial and Medicare risk populations.

Denominator: Three separate denominators, one for each of the three required calculations, are derived using random samples of 411 Medicaid members, 411 commercial members and 411 Medicare risk members from the plan's eligible populations. Eligible members include Medicaid, commercial and Medicare risk members with diabetes age 31 years or older as of December 31 of the reporting year, who were members as of December 31 of the reporting year and who were continuously

enrolled during the reporting year. Enrollees who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure. See the administrative data specification for definition of the diabetic population by ambulatory prescription drug and claim/encounter records.

Numerator: The number of members in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) who received a retinal examination during the reporting year, as documented through either administrative data or medical record review. For medical record review, a retinal examination is documented by:

A note or letter from an ophthalmologist, optometrist or other health care provider summarizing the date the procedure was performed and the results of an evaluation performed by an eye-care professional.

OR

A chart or photograph of retinal abnormalities. If fundus photography was used, there must be documentation in the medical record indicating the date the procedure was performed and evidence that the results were reviewed by an eye-care professional.

OR

An author-identified note, which may be prepared by a primary care provider, indicating the date the procedure was performed and that an ophthalmoscopic exam was completed by an eye-care professional, with results of the exam.

Notes

- The CPM recognizes that the frequency of retinal screening in diabetics is influenced by the type of diabetes and the presence and degree of retinopathy. In summary, annual screening may not be indicated for every diabetic patient. Therefore, one would not necessarily expect a screening rate of 100% in each plan. Ideally, this measure should report diabetic retinal screening stratified on the basis of risk for developing vision-threatening retinopathy. The feasibility and validity of specifications that allow such stratification of the diabetic population will be evaluated during 1997.
- For purposes of this measure, an "eye-care professional" is an optometrist or ophthalmologist.
- This measure calculates the rate of performance of a regular eye exam in a defined patient population. The performance does not demonstrate whether effective treatment was provided to the patient.
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.

- The likelihood that a member has received a retinal exam based on the presence of the CPT-4 codes cited is uncertain. A number of CPT-4 codes for other ophthalmic services have been excluded. It is unclear whether their exclusion will lead to underreporting of the rate of retinal exams.
- There is consensus among the American Diabetes Association, National Eye Institute, and American Academy of Ophthalmology that dilation of the pupil is necessary to ensure optimal examination of the retina. However, the current coding structure permits us to know only whether an eye exam was performed and not whether the pupil was dilated. This measure represents a minimum rather than an optimum standard, but the CPM believes that it is nonetheless valuable in improving existing preventive eye care for diabetics.
- A plan with as few as 10,000 enrollees would be expected to have at least 100 diabetics.
- Plans that use only pharmacy data to identify their diabetic population should also document the percentage of all their members age 31 years and older for whom the health plan manages or provides a pharmacy benefit.
- Plans may exclude members who, through medical record review, are identified as not being diabetic.

THE HEALTH OF SENIORS

New Measure

Description

The percentages of senior Medicare risk plan members, age 65 years and older, whose self-reported health status has improved, stayed the same or worsened. Change is measured over two years and has two components — mental and physical.

Specifications

Calculation: The SF-36, plus additional items for risk adjustment, will be mailed at the outset and two years later; the additional items are a checklist of morbid conditions, self-evaluated change in status, a three-level income question, number in household, social support, education, race, age and sex. The mental and physical components are scored according to published methodology[1]. The change in the responses from year 1 to year 3 will be compared to an expected change. Individual members will be categorized as 'worse' if the change in their functional scores are negative and larger than expected. They will be classified as 'same' if the change in functional scores are within the expected range, and 'better' if the change in their scores is positive and larger than expected. The resulting percentages in each category will be adjusted for the additional comorbid conditions and socioeconomic factors collected in the survey.

Denominator: A random sample of 1,000 Medicare risk enrolled adults age 65 years and older who have been continuously enrolled for at least six months; these members will be surveyed at baseline and again after two years. For the mental component, the denominator consists of all persons who complete both surveys. For the physical component, the denominator also includes persons who die or who move into long-term facilities and do not return the questionnaire. In these last two cases, the members will be counted as having worsened.

Numerators: Three numerators are calculated using the number of respondents two years later who fall in the following categories.

"Better" — change in functional scores positive and larger than expected

"Same — change in functional scores not larger than expected in either direction

"Worse" — change in functional scores negative and larger than expected

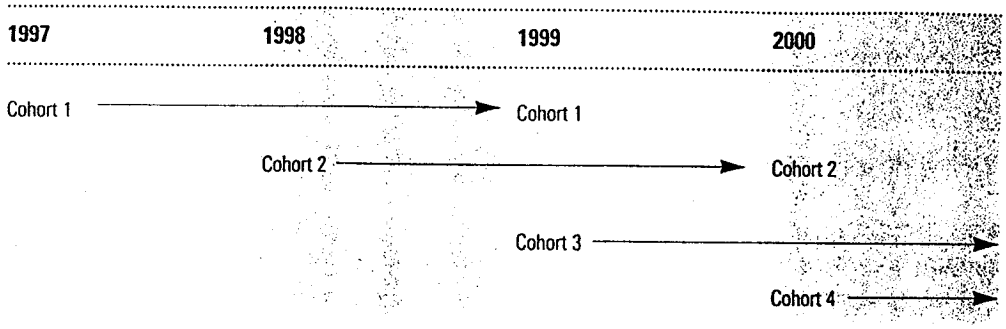
Separate rates are reported for mental and physical scores and will be risk-adjusted as described below, incorporating the additional items collected.

Implementation Approach

Sampling: Each year, a new cohort will be selected from the eligible enrollment. The survey will be administered as described in the table below. Two years after each cohort receives the survey, they will receive it again, and their baseline compared to the two-year score. The comparison is denoted by the arrowed lines:

[1] SF-36 Physical and Mental Summary Scales: User's Manual, Ware et al pp. 4:3-4:4

Cohort Surveys and Comparisons



Analysis: Two sets of analysis are performed in the calculation of the measure:

- Significance of Change in Status — For each respondent who completed both a baseline and a two-year follow-up survey, the functional health score from the first questionnaire is subtracted from the second score. The difference between mental health scores is classified as "better," "same" or "worse" according to the direction of change and whether the amount is greater or less than expected from chance variation. This will be accomplished by comparing the difference to the 95% confidence interval for an individual scale[2]. The physical health score will also be compared to expected performance; in addition, respondents who died or moved to a long-term facility after completing the first survey will be counted as worse on the physical score.
- Risk Adjustment — The proportions of individuals who are "better," "same" or "worse" will be adjusted using multinomial logistic regression models. These adjusted proportions will be the final reported measures. See the Risk Adjustment Methodology below for more detail regarding these calculations.

Responsibilities of the Plan: The plan will provide its complete eligible enrollment file to an external party each year for sampling. Single-year rates by plan will be reported to HCFA, beginning in 1997, to establish baseline functional status associated with plan. Change scores will first be available in 1999.

Information Reports to Plans: Each year the plan will receive aggregated physical and mental scores, as well as the scales that make up those aggregated scores:

Physical Health

Physical Functioning

Role-Physical

Bodily Pain

General Health

Mental Health

Vitality

Social Functioning

Role-Emotional

Mental Health

[2] SF-36 Physical and Mental Summary Scales: User's Manual, Ware et al pp. p. 5:10

The plan will not receive data on individual responses, for reasons of confidentiality and scientific validity.

Responsibilities of External Parties: All survey administration, data collection and analysis will be done external to the plan.

Notes

- NCQA is sensitive to the additional burden this very important measure places on plans, and is working closely with HCFA to examine possibilities for burden reduction. Plans will be notified by NCQA when details are available.
- To order the SF-36 Health Survey Manual and Interpretation Guide, call the Medical Outcomes Trust at 1 (800)-572-9394.

Risk Adjustment Methodology

Suppose the variables for risk adjustment are x1, x2, etc. Two functions are calculated for each individual:

Lbetter = exp(b0+b1*x1+b2*x2+....)

Lworse = exp(c0+c1*x1+c2*x2+....),

where b0, b1...c0, c1... are coefficients supplied from models developed in the MOS and NHSF studies in the first report and (" * ") represents multiplication. (In subsequent years, the data collected from this effort will be used to refine the model.)

For each individual, the probability of getting better is
Xbetter = Lbetter/(Lbetter+Lworse+1).

The probability of staying the same is
Xsame = 1/(Lbetter+Lworse+1).

The probability of getting worse is
Xworse = Lworse/(Lbetter+Lworse+1).

The percentages better, same and worse observed for equivalent individuals (i.e., risk-adjusted percentages) will be reported, as follows:

Abetter = Xbetter/(Xbetter+Xsame+Xworse)

Asame = Xsame/(Xbetter+Xsame+Xworse)

Aworse = Xworse/(Xbetter+Xsame+Xworse)

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *The expanded mental health diagnosis codes specified in Medicaid HEDIS have been adopted.*
- ➤ *ICD-9-CM code 300.3 has been added.*
- ➤ *The age range has been expanded to include individuals age 6 through 10 years and 65 years and older.*
- ➤ *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- ➤ *An exclusionary rule has been added for members who have been discharged directly from the hospital to another inpatient facility (e.g., nursing facility, residential treatment facility).*

Description

The percentage of Medicaid, commercial and Medicare risk members age six years and older who were hospitalized for treatment of selected mental health disorders who were continuously enrolled without breaks for 30 days after discharge, and who were seen on an ambulatory basis or were in day/night treatment within 30 days of hospital discharge.

Administrative Data Specification

Calculation: This specification uses either hospital inpatient discharge summaries or the UB-92 to identify those members who have been discharged with a selected mental health diagnosis and uses encounter data (HCFA 1500, UB-92, or equivalent) to identify those who have received appropriate follow-up care. Separate calculations are required for the Medicaid, commercial and Medicare risk populations.

Denominator: Three separate denominators, one for each of the three required calculations, are derived by counting discharges for members age six years and older at the time of discharge who have been hospitalized with a discharge date occurring during the first 330 days of the reporting year and a principal ICD-9-CM diagnosis code indicating a mental health disorder specified below, and who were continuously enrolled without breaks for 30 days after discharge.

Note: This measure is restricted to inpatient hospitalization. Do not count members discharged from residential care or rehabilitation programs.

The following mental health diagnoses are included in this measure:

ICD-9-CM 295.xx	Schizophrenic disorders
ICD-9-CM 296.0x	Manic disorder, single episode
ICD-9-CM 296.1x	Manic disorder, recurrent episode
ICD-9-CM 296.2x	Major depressive disorder, single episode
ICD-9-CM 296.3x	Major depressive disorder, recurrent episode
ICD-9-CM 296.4x	Bipolar affective disorder, manic

ICD-9-CM 296.5x	Bipolar affective disorder, depressed
ICD-9-CM 296.6x	Bipolar affective disorder, mixed
ICD-9-CM 296.7x	Bipolar affective disorder, unspecified
ICD-9-CM 296.8x	Manic-depressive psychosis, other and unspecified
ICD-9-CM 296.9x	Other and unspecified affective psychoses
ICD-9-CM 297.x	Paranoid states
ICD-9-CM 298.x	Other nonorganic psychoses
ICD-9-CM 299.xx	Psychoses with origin specific to childhood
ICD-9-CM 300.3	Obsessive-compulsive disorders
ICD-9-CM 301.x	Personality disorders
ICD-9-CM 308.x	Acute reaction to stress
ICD-9-CM 309.xx	Adjustment reaction
ICD-9-CM 311	Depressive disorder, not otherwise classified
ICD-9-CM 312.xx	Disturbance of conduct, not elsewhere classified
ICD-9-CM 313.xx	Disturbance of emotions specific to childhood and adolescence
ICD-9-CM 314.xx	Hyperkinetic syndrome of childhood

If a member has more than one discharge during the 330-day period with a diagnosis of one of the selected mental health disorders listed above, that member may be reflected more than once in the rate. Therefore, a plan should count discharges, not individuals. However, if a discharge for one of the selected mental health disorders is followed by a readmission for any mental health or chemical dependency diagnosis within the 30-day follow-up period, only the readmission discharge should be counted. Although the rehospitalization might not be for one of the selected mental health disorders, it most likely is for a related condition.

Numerator: The number of discharges in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) that were followed by an ambulatory mental health encounter or day/night treatment within 30 days of hospital discharge. To identify ambulatory follow-up encounters, use the CPT-4 codes listed below or the UB-92 revenue codes of 901 (psychiatric/psychological treatments, electroshock treatment), 911 (rehabilitation), 912 (psychiatric/psychological services, day care), 913 (psychiatric/psychological services, night care), 914 (individual therapy), 915 (group therapy), 916 (family therapy) or 513 (clinic-psychiatric). The follow-up visit must be with a mental health provider and can be for any mental health diagnosis. Health plans may use Level III HCPCS codes to identify follow-up visits, as long as the codes can be mapped to the service categories represented by the following codes:

CPT-4 codes:

90801	Diagnostic assessment
90820	Interactive interview examination
90841	MD psychotherapy
90842	MD psychotherapy

90843	MD psychotherapy
90844	MD psychotherapy
90845	Medical psychoanalysis
90847	Family psychotherapy
90849	Multifamily group therapy
90853	Group psychotherapy
90855	Individual psychotherapy
90857	Group psychotherapy
90862	Pharmacology management
90870-90871	Electroconvulsive therapy

Hybrid Method Specification

Calculation: This specification uses either hospital inpatient discharge summaries or the UB-92 to identify those members who have been discharged with a selected mental health diagnosis and uses encounter data (HCFA 1500, UB-92, or equivalent) to identify those who have received appropriate follow-up care. Separate calculations are required for the Medicaid, commercial and Medicare risk populations.

Denominator: Three separate denominators, one for each of the three required calculations, are derived using random samples of 411 Medicaid members, 411 commercial members and 411 Medicare risk members from the plan's eligible populations. Using hospital discharge data, identify discharges for Medicaid, commercial and Medicare risk members who were age six years and older at the time of discharge, hospitalized with a discharge date occurring during the first 330 days of the reporting year and a principal ICD-9-CM diagnosis code indicating the mental health disorders specified below, and who were continuously enrolled without breaks for 30 days after discharge.

The following mental health disorder diagnoses are used for this measure:

ICD-9-CM 295.xx	Schizophrenic disorders
ICD-9-CM 296.0x	Manic disorder, single episode
ICD-9-CM 296.1x	Manic disorder, recurrent episode
ICD-9-CM 296.2x	Major depressive disorder, single episode
ICD-9-CM 296.3x	Major depressive disorder, recurrent episode
ICD-9-CM 296.4x	Bipolar affective disorder, manic
ICD-9-CM 296.5x	Bipolar affective disorder, depressed
ICD-9-CM 296.6x	Bipolar affective disorder, mixed
ICD-9-CM 296.7x	Bipolar affective disorder, unspecified
ICD-9-CM 296.8x	Manic-depressive psychosis, other and unspecified
ICD-9-CM 296.9x	Other and unspecified affective psychoses
ICD-9-CM 297.x	Paranoid states

ICD-9-CM 298.x	Other nonorganic psychoses
ICD-9-CM 299.xx	Psychoses with origin specific to childhood
ICD-9-CM 300.3	Obsessive-compulsive disorders
ICD-9-CM 301.x	Personality disorders
ICD-9-CM 308.x	Acute reaction to stress
ICD-9-CM 309.xx	Adjustment reaction
ICD-9-CM 311	Depressive disorder, not otherwise classified
ICD-9-CM 312.xx	Disturbance of conduct, not elsewhere classified
ICD-9-CM 313.xx	Disturbance of emotions specific to childhood and adolescence
ICD-9-CM 314.xx	Hyperkinetic syndrome of childhood

If a member has more than one discharge during the 330-day period with a diagnosis of one of the selected mental health disorders listed above, that member may be reflected more than once in the sampling frame. However, if a discharge for one of the selected mental health disorders is followed by a readmission for any mental health or chemical dependency diagnosis within the 30-day follow-up period, only the readmission discharge should be counted. Although the rehospitalization might not be for one of the selected mental health disorders, it most likely is for a related condition.

Numerator: The number of discharges in the denominator for each of the three populations (Medicaid, commercial, and Medicare risk) for which there is documentation of an ambulatory mental health encounter or day/night treatment within 30 days of discharge, as documented through either administrative data or medical record review. The follow-up visit must be with a mental health provider and can be for any mental health diagnosis.

Notes

- If a Medicaid, commercial or Medicare risk member identified in the denominator of this measure is rehospitalized for a non-mental health, non-chemical dependency diagnosis within 30 days of discharge for one of the selected mental health disorder hospitalizations, that member should be dropped from this measure, because the rehospitalization may prevent an ambulatory follow-up visit from taking place.
- Plans may exclude from the denominator those individuals who have been discharged directly from the hospital to a non-acute setting (e.g., nursing facility, residential treatment facility). This is a change from HEDIS 2.5 and Medicaid HEDIS in an effort to produce more accurate rates.
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.

FREQUENCY OF ONGOING PRENATAL CARE

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

➤ *This measure, from the Quality of Care section in Medicaid HEDIS, has been moved to the Use of Services domain. It remains applicable only to the Medicaid population.*

Note: This measure is significant and relevant to both Medicaid and commercial enrollees. However, because this measure has been newly developed for Medicaid HEDIS and not yet implemented, the CPM agreed that it should continue to be required for Medicaid enrollees, and be evaluated for the commercial population. By implementing this measure in state Medicaid programs, valuable information will be available to help assess the measure's applicability to a broader population.

Description

The percentage of pregnant Medicaid-enrolled women who received < 21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the expected number of prenatal care visits, adjusted for gestational age and the month prenatal care began.

Administrative Data Specification

Calculation: This specification uses hospital discharge and membership data to identify the number of live deliveries to enrolled women during the reporting year. Hospital discharge data, hospital records, birth certificates, or claims/encounter data are used to compare the number of prenatal care visits a woman received while in the plan to the expected number of visits, adjusted for the month prenatal care began and gestational age.

For each woman who had (a) live birth(s) during the reporting year, the plan will: 1) identify the actual number of prenatal care visits, 2) identify the number of expected visits, 3) calculate the ratio of received-to-expected visits, and 4) report an unduplicated count of the number of women who had <21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits, adjusted for the month prenatal care began in the plan and gestational age. Plans will report five rates.

Denominator: All Medicaid enrolled women who delivered (a) live birth(s) during the reporting year.

Note: To ensure the completeness and validity of live-birth information, plans often use several data sources with different coding schemes. Codes are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone, while others may be used as part of a combination of codes (e.g., V codes may be used alone; CPT-4 procedure codes may be used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed to document live births, the plan is responsible for verifying that only live births are included in this measure.

To identify deliveries resulting in live births, women who have been discharged with one of the following codes should be counted:

DRG codes: 370-375. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

Numerator: The number of women in the denominator who had an unduplicated count of <21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits, adjusted for the month prenatal care began and gestational age. Use the following steps to calculate each woman's ratio of observed-to-expected prenatal care visits.

For each woman included in the denominator:

- Identify date of delivery, using hospital discharge data.
- Identify gestational age at birth from the hospital record (e.g., admission write-ups, histories and physicals, discharge summaries or labor and delivery records) or birth certificate. Gestational age is defined as the number of completed weeks that have elapsed between the first day of the last normal menstrual period and the date of delivery. Methods recommended to determine gestational age are: 1) physician ascertainment using ultrasound or Dubowits assessment, and 2) last menstrual period (LMP) calculation (Date of LMP – Date of delivery ÷ 7). If gestational age is recorded or calculated in fractions of a week, round down to the lower whole number.

- ➤ Identify the date on which prenatal care began while enrolled in the plan, using encounter data.
- ➤ Using gestational age (from Step 2), determine the number of ACOG-recommended visits a woman should have received from the time prenatal care was initiated (refer to Table 5A). ACOG recommends that women with an uncomplicated pregnancy receive visits every four weeks for the first 28 weeks of pregnancy, every two to three weeks until 36 weeks of gestation, and weekly thereafter.
- ➤ Using Table 5A, adjust the number of expected ACOG prenatal visits by gestational age and the month prenatal care began during enrollment in the plan. The chart subtracts the number of missed visits prior to the date prenatal care began (Step 3) from the number of recommended visits for a given gestational age. For example, ACOG recommends 14 visits for a 40-week gestation. If care began in month four (three missed visits during enrollment in the plan), the expected number of visits is 14 – 3 = 11.
- ➤ Identify the number of prenatal care visits the member received during the course of her pregnancy and enrollment in the health plan using ambulatory/encounter data.

Note: *We recommend that plans use Table 1E in the Prenatal Care in the First Trimester measure as the basis of their search to identify prenatal care visits. Plans may use any of the four rules presented in that table to search for evidence of prenatal care; a woman's record need satisfy only one of the rules. In addition to the other codes listed in the table, plans may also use CPT-4 code 76810 in Decision Rules 2 and 3. Plans should document their method for identifying prenatal care, whether or not these decision rules were followed.*

- ➤ Calculate the ratio of observed visits (Step 6) over expected visits (Step 5).
- ➤ Report each woman in the appropriate category: <21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits. Plans should report five numerators.

Hybrid Method Specification

Calculation: This specification uses hospital discharge and membership data to identify the number of live deliveries to enrolled women during the reporting year. Hospital discharge data, hospital records, birth certificates, or claims/encounter data and/or medical record review are used to compare the number of prenatal care visits a woman received while in the plan to the expected number of visits, adjusted for the month prenatal care began in the plan and gestational age.

Denominator: A random sample of 411 Medicaid members drawn from the plan's eligible population. Eligible members include Medicaid enrolled women who delivered (a) live birth(s) during the reporting year.

Note: *To ensure the completeness and validity of live-birth information, plans often use several data sources with different coding schemes. Codes are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone, while others may be used as part of a combination of codes (e.g., V codes may be used alone; CPT-4 procedure codes may be used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed to document live births, the plan is responsible for verifying that only live births are included in this measure.*

To identify deliveries resulting in live births, women who have been discharged with one of the following codes should be counted:

DRG codes: 370-375. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

Numerator: The number of enrolled women in the sample who had an unduplicated count of <21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits, adjusted for the month prenatal care began while enrolled in the plan and gestational age. The visit may be identified through either administrative data or medical record review. Use the steps provided in the administrative data specifications above to adjust the number of expected prenatal visits for the month prenatal care began while enrolled in the plan and gestational age. For (a) prenatal care visit(s) to a midwife or OB provider, documentation in the medical record must include an author-identified note indicating the date on which the prenatal care visit(s) occurred and evidence of one of the following:

A basic physical obstetrical examination that includes either auscultation for fetal heart tone, or pelvic exam with obstetric observations or measurement of fundus height (a standardized prenatal OB form may be used).

OR

Evidence that a prenatal care procedure was performed, such as a screening test in the form of either an obstetric panel, or a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing and/or echography of a pregnant uterus.

OR

Evidence that a diagnosis of pregnancy has been established, in the form of a complete medical and obstetrical history and documentation of last menstrual period (LMP) or estimated date of confinement (EDC).

OR

Documentation of LMP or EDC in conjunction with either prenatal risk assessment and counseling/education or a complete obstetrical history.

For (a) prenatal care visit(s) to a family practitioner or other primary care provider, documentation in the medical record must include an author-identified note indicating the date on which the prenatal care visit(s) occurred and evidence of one of the following:

A basic physical obstetrical examination that includes either auscultation for fetal heart tone, or pelvic exam with obstetric observations or measurement of fundus height (a standardized prenatal OB form may be used).

OR

Evidence that a prenatal care procedure was performed, such as screening test in the form of either an obstetrical panel, or a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, and/or echography of a pregnant uterus and evidence that a diagnosis of pregnancy has been established, in the form of a complete medical and obstetrical history and documentation of last menstrual period (LMP) or estimated date of confinement (EDC).

OR

Evidence that a prenatal care procedure was performed, such as a screening test in the form of either an obstetric panel, a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, an antenatal screen, and/or echography of a pregnant uterus and evidence that a diagnosis of pregnancy has been established in the form of a documented LMP or EDC in conjunction with either prenatal risk assessment and counseling/education or a complete obstetrical history.

Note that the numerator is calculated retroactively from time of delivery or estimated date of confinement.

Notes

- For a prenatal care visit to a family practitioner or other primary care provider, documentation in the medical record at the time of the prenatal care visit need not include a complete medical history if the primary care provider is the patient's regular doctor and has documented the patient's medical history elsewhere in the medical record.
- By specifying the population at risk to include only live births, this measure captures only a percentage of a plan's Medicaid members' pregnancies.
- Women who delivered in a birthing center should be included in this measure.
- When counting prenatal visits, include visits to physicians, nurse practitioners and midwives, as well as registered nurses provided that evidence of co-signature by a physician is present, if required by state law.
- This measure does not have a continuous enrollment criterion, since pregnancy is a criterion for Medicaid eligibility; it is very unlikely that a woman enrolled during pregnancy would disenroll and re-enroll during this period.

Table 5A: Expected Number of Prenatal Care Visits for a Given Gestational Age and Month Prenatal Care Began

	Gestational Age in Weeks																
Month prenatal care began	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**	**40**	**41**	**42**	**43**	**44**
9th month	-	-	-	-	-	-	-	-	-	-	-	1	1	2	3	4	5
8th month	-	-	-	-	-	-	1	1	1	2	3	4	5	6	7	8	9
7th month	-	-	1	1	1	1	2	2	3	4	5	6	7	8	9	10	11
6th month	1	1	1	1	2	2	3	3	4	5	6	7	8	9	10	11	12
5th month	1	1	2	2	3	3	4	4	5	6	7	8	9	10	11	12	13
4th month	3	3	4	4	5	5	6	6	7	8	9	10	11	12	13	14	15
3rd month	4	4	5	5	6	6	7	7	8	9	10	11	12	13	14	15	16
2nd month	5	5	6	6	7	7	8	8	9	10	11	12	13	14	15	16	17
1st month	6	6	7	7	8	8	9	9	10	11	12	13	14	15	16	17	18

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

➤ *This measure, from the Quality of Care section in Medicaid HEDIS, has been moved to the Use of Services domain and now applies to the commercial population as well.*

Description

The percentage of Medicaid and commercially enrolled members who turned 15 months old during the reporting year, who were continuously enrolled in the plan from 31 days of age, and who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care provider during their first 15 months of life. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.

Administrative Data Specification

Calculation: This specification uses membership data to identify members who have turned 15 months old during the reporting year. Claims/encounter data are used to identify those members who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care provider during their first 15 months of life.

Primary care providers are defined as health care practitioners whom members are able to select as primary care providers as their first point of entry into the system and who are defined by the plan as primary care providers for that purpose.

Health plans will calculate seven rates for each of the two populations (Medicaid and commercial). A child should be included in only one numerator (e.g., a child receiving six well-child visits will not be included in the rate for five, four or fewer well-child visits).

Denominator: For each population (i.e., Medicaid and commercial), the denominators are the same for all seven rates: All members who turned age 15 months during the reporting year, who were members of the plan as of the day they turned age 15 months and who were continuously enrolled in the health plan from 31 days of age. Members who have had no more than one break in enrollment of up to 45 days should be included in this measure.

Note: *Calculate 31 days of age by adding 31 days to the child's date of birth. Calculate the 15-month deadline as the child's first birthday plus 90 days. For example, if a child, born on January 9, 1995, is included in the rate of six or more well-child visits, he or she must have had six well-child visits by April 9, 1996.*

Numerator: For each population (i.e., Medicaid and commercial), seven separate numerators are calculated, corresponding to the number of members in the denominator who received either zero, one, two, three, four, five, or six or more well-child visits with

a primary care provider during their first 15 months of life. A child is considered to have received a well-child visit if he or she had a claim/encounter that meets one of the following criteria:

CPT-4 codes:
Preventive medicine services

99381	New patient under one year
99382	New patient (ages 1-4 years)
99391	Established patient under one year
99392	Established patient (ages 1-4 years)
99431	Newborn care (history and examination)
99432	Normal newborn care

OR

ICD-9-CM codes:

V20-V20.2	Health supervision of infant and child
V70.0	General medical examination (routine)
V70.3-V70.9	General medical examination

Note: *The above CPT-4 and ICD-9-CM codes may be used alone or with other codes.*

OR

CPT-4 codes:
Evaluation and management codes

99201-99205	New patient
99211-99215	Established patient

Note: *These CPT-4 codes must be used in conjunction with V codes V20-V20.2 and/or V70.0 and/or V70.3-70.9.*

Hybrid Method Specification

Calculation: This specification uses membership data to identify members who turned 15 months old during the reporting year. Claims/encounter data and/or medical record review are used to identify those members who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care provider during their first 15 months of life.

Primary care providers are defined as health care practitioners whom members are able to select as primary care providers as their first point of entry into the system and who are defined by the plan as primary care providers for that purpose.

Health plans will calculate seven rates for each of the two populations separately (Medicaid and commercial). A child should be included in only one numerator (e.g., a child receiving six well-child visits will not be included in the rate for five, four or fewer well-child visits).

Denominator: For each population (i.e., Medicaid and commercial), the denominators are the same for all seven rates: A random sample of 411 Medicaid members and 411 commercial members drawn from the health plan's eligible populations. Eligible members include Medicaid and commercial members who turned age 15 months during the reporting year, who were members of the plan as of the day they turned age 15 months, and who were continuously enrolled from 31 days of life. Members who have had no more than one break in enrollment of up to 45 days should be included in this measure.

Note: *Calculate 31 days of age by adding 31 days to the child's date of birth. Calculate the 15-month deadline as the child's first birthday plus 90 days. For example, if a child, born on January 9, 1995, is included in the rate of six or more well-child visits, he or she must have had six well-child visits by April 9, 1996.*

Numerator: For each population (i.e., Medicaid and commercial), seven separate numerators are calculated, corresponding to the number of enrolled members in the sample who received either zero, one, two, three, four, five or six or more well-child visits with a primary care provider during their first 15 months of life, as documented through either administrative data or medical record review. Documentation in the medical record must include an author-identified note indicating the date on which the well-child visit occurred and, at a minimum, evidence of the following: a health and developmental history, both physical and mental; a physical exam; and health education/anticipatory guidance.

Notes

- For health plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.
- Inpatient, emergency room, mental health, chemical dependency and specialist visits should not be counted in this measure. The intent is to capture comprehensive well-child visits only.
- Plans with internal codes or other transaction data not cited above for Medicaid members, that denote an EPSDT well-child visit, may use these codes as long as they document methods used to track EPSDT well-child visits.
- Some states that have specific EPSDT codes for Medicaid beneficiaries may require plans to apply these codes when using administrative data specifications.
- The CPM realizes that preventive services may be rendered on the occasion of visits other than well-child visits. If the specified codes are present, these services may be counted, regardless of the primary intent of the visit.

WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH AND SIXTH YEAR OF LIFE

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from the Quality of Care section in Medicaid HEDIS, has been moved to the Use of Services domain and now applies to the commercial population as well.*
- ➤ *The age range has been expanded to include three-year olds, conforming with the American Academy of Pediatrics Periodicity Schedule.*

Description

The percentage of Medicaid and commercially enrolled members who were three, four, five or six years old during the reporting year, who were continuously enrolled during the reporting year, and who received one or more well-child visit(s) with a primary care provider during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year are included in this measure.

Administrative Data Specification

Calculation: This specification uses membership data to identify members who are three, four, five or six years old during the reporting year. Claims/encounter data are used to identify those members who received one or more well-child visit(s) with a primary care provider during the reporting year. Separate calculations are required for the Medicaid and commercial populations.

Primary care providers are defined as health care practitioners whom members are able to select as primary care providers as their first point of entry into the system and who are defined by the plan as primary care providers for that purpose.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using all members who were three, four, five or six years old as of December 31 of the reporting year and who were continuously enrolled during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year are included in this measure.

Numerator: The number of members in the denominator for each of the two populations (Medicaid and commercial) who received at least one well-child visit with a primary care provider during the reporting year. A child is considered to have received a well-child visit if he/she had a claim/encounter with a primary care provider that meets one of the following criteria:

CPT-4 codes:
Preventive medicine services

99382	New patient (ages 1 through 4 years)
99383	New patient (ages 5 through 11 years)
99392	Established patient (ages 1 through 4 years)
99393	Established patient (ages 5 through 11 years)

OR

ICD-9-CM codes:

V20-V20.2	Health supervision of infant and child
V70.0	General medical examination (routine)
V70.3-V70.9	General medical examination

Note: The CPT-4 and ICD-9-CM codes above may be used alone or with other codes.

OR

CPT-4 codes:
Evaluation and management codes

99201-99205	New patient
99211-99215	Established patient

Note: These CPT-4 codes must be used in conjunction with V codes V20-V20.2 and/or V70.0 and/or V70.3-70.9.

Hybrid Method Specification

Calculation: This specification uses membership data to identify members who were three, four, five or six years old. Claims/encounter data and/or medical record review are used to identify those members who have had one or more well-child visit with a primary care provider during the reporting year. Separate calculations are required for the Medicaid and commercial populations.

Primary care providers are defined as health care practitioners whom members are able to select as primary care providers as their first point of entry into the system and who are defined by the plan as primary care providers for that purpose.

Denominator: Two separate denominators, one for each of the required calculations, are derived from a random sample of 411 Medicaid members and 411 commercial members drawn from the plan's eligible populations. Eligible members are those members who were three, four, five or six years old as of December 31 of the reporting year, who were continuously enrolled during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year are included in this measure.

Numerator: The number of enrolled members in the denominator for each of the two populations (Medicaid and commercial) who have had at least one well-child visit with a primary care provider during the reporting year, as documented through either administrative data or medical record review. Documentation in the medical record must include an author-identified note indicating the date on which the well-child visit occurred and, at a minimum, evidence of the following: a health and developmental history, both physical and mental; a physical exam; and health education/anticipatory guidance.

Notes

- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for health plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.
- Inpatient, emergency room, mental health, chemical dependency and specialist visits should not be counted in this measure. The intent is to capture comprehensive well-child visits only.
- Plans that use internal codes or other transaction data not cited above to denote an EPSDT well-child visit may use these codes, as long as the method used to track EPSDT well-child visits is documented.
- Some states that have specific EPSDT codes may require plans to apply these codes when using administrative data specifications.
- Visits to school-based clinics may be counted if documentation of a well-child exam is available in the medical record or administrative system before December 31 of the reporting year (i.e., entries made retroactive to the reporting year are not counted).
- The CPM recognizes that preventive services may be rendered on the occasion of visits other than well-child visits. If the specified codes are present, these services may be counted, regardless of the primary intent of the visit.

ADOLESCENT WELL-CARE VISITS

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

➤ *This measure, from the Quality of Care section in Medicaid HEDIS, has been moved to the Use of Services domain and now applies to the commercial population as well.*

Description

The percentage of Medicaid and commercially enrolled members who were age 12 through 21 years during the reporting year who were continuously enrolled during the reporting year and who have had at least one comprehensive well-care visit with a primary care provider during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Administrative Data Specification

Calculation: This measure uses membership data to identify members who were age 12 through 21 years during the reporting year. Claims/encounter data are used to identify those members who received one or more comprehensive well-care visits with a primary care provider during the reporting year. Separate calculations are required for the Medicaid and commercial populations.

Primary care providers are defined as health care practitioners whom members are able to select as primary care providers as their first point of entry into the system and who are defined by the plan as primary care providers for that purpose.

Denominator: Two separate denominators, one for each of the required calculations, are derived using all members age 12 through 21 years as of December 31 of the reporting year who were continuously enrolled during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Numerator: The number of members in the denominator for each of the two populations (Medicaid and commercial) who have had at least one comprehensive well-care visit with a primary care provider during the reporting year. An adolescent is considered to have received a comprehensive well-care visit if he or she had a claim/encounter that meets one of the following criteria:

CPT-4 codes:
Preventive medicine services

99383	New patient (5 through 11 years)
99384	New patient (12 through 17 years)
99385	New patient (18 through 39 years)
99393	Established patient (5 through 11 years)
99394	Established patient (12 through 17 years)
99395	Established patient (18 through 39 years)

OR

ICD-9-CM codes

V20-V20.2	Health supervision of infant and child
V70.0	General medical examination (routine)
V70.3-V70.9	General medical examination

Note: The above CPT-4 and ICD-9-CM codes may be used alone or with other codes.

OR

CPT-4 codes:
Evaluation and management codes

99201-99205	New patient
99211-99215	Established patient

Note: These CPT-4 codes must be used in conjunction with V codes V20-20.2, V70.0 and V70.3-70.9.

Hybrid Method Specification

Calculation: This specification uses membership data to identify members who were age 12 through 21 years during the reporting year. Claims/encounter data and/or medical record review are used to identify those members who have had at least one comprehensive well-care visit with a primary care provider during the reporting year. Separate calculations are required for the Medicaid and commercial populations.

Primary care providers are defined as health care practitioners whom members are able to select as primary care providers as their first point of entry into the system and who are defined by the plan as primary care providers for that purpose.

Denominator: Two separate denominators, one for each of the required calculations, are derived from random samples of 411 Medicaid members and 411 commercial members drawn from the plan's eligible populations. Eligible members include Medicaid and commercial members who were age 12 through 21 years as of December 31 of the reporting year who were continuously enrolled during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Numerator: The number of enrolled members in the denominator for each of the two populations (Medicaid and commercial) who received at least one comprehensive well care visit with a primary care provider during the reporting year, as documented through either administrative data or medical record review. Documentation in the medical record must include an author-identified note indicating the date on which the well-care visit occurred and, at a minimum, evidence of the following: a health and developmental history, both physical and mental; a physical exam, and health education/anticipatory guidance.

Notes

- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for health plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.
- Inpatient, emergency room, mental health, chemical dependency and specialist visits should not be counted in this measure. The intent is to capture comprehensive well-care visits only.
- Plans with internal codes, or other transaction data not cited above for Medicaid members, that denote an EPSDT well-child visit may use these codes as long as the method used to track EPSDT well-child visits is documented.
- Some states that have specific EPSDT codes for Medicaid beneficiaries may require plans to apply these codes when using administrative data specifications.
- Visits to school-based clinics may be counted if documentation that a well-child exam occurred is available in the medical record or administrative system before December 31 of the reporting year (i.e., entries made retroactive to the reporting year are not counted).
- The CPM recognizes that preventive services may be rendered on the occasion of visits other than well-child visits. If the specified codes are present, these services may be counted, regardless of the primary intent of the visit.